

Today's Date: _____ Whom may we thank for referring you? _____

First Name: _____ Last Name: _____ Middle: _____

Gender: Male Female Marital Status: M S W D Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail address: _____ Preferred Contact method: *(Please Check)*
 Home Phone Work Phone Cell Phone E-mail
Social Security # _____ Cell Carrier _____ (ex. Verizon/smart talk/ At&T)
used only to text appt. reminders

Occupation: _____ Employer: _____

Spouse's Name: _____ Date of Birth: _____ Primary Physician: _____

Emergency Contact: _____ Emergency Contact phone # _____

How can we help you today? _____

Acknowledgements – To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initial _____ I have read and reviewed the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for insurance and/or medical records purposes.

Initial _____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period: (MM/DD/YYYY) _____

Initial _____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.

Initial _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initial _____ I may request a copy of the Financial Policy at any time.

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature

Date (MM/DD/YYYY)

If the patient is a minor child, print child's full name: _____

Please Continue on the Back Side

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of procedures, including various modes of physio therapy, chiropractic adjustments, examinations, acupuncture, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by The BAC Clinic of Chiropractic and/or any other licensed providers and support staff who now or in the future treat me while employed by, working or associated with or servicing as back-up providers for The BAC Clinic of Chiropractic.

I have had an opportunity to discuss with the provider and/or with other office or clinic personnel the nature and purpose of the procedures.

I understand and I am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect The BAC Clinic of Chiropractic to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course for the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest.

I further understand that treatment is designed to improve health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued.

I further understand that there are treatment options available for my condition, these treatment options include, but are not limited to self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: _____

Signature of Patient: _____

Name Printed of Guardian/Parental and Relationship to Patient: _____

Guardian/Parental Signature: _____

Date: _____

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